

		FOR OHF USE					

LL 1

**2003**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2003)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0039651</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>																	
<b>Facility Name:</b> <u>Virgil Calvert Nursing Ctr</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/03</u> to <u>12/31/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																	
<b>Address:</b> <u>5050 Summit Avenue</u> <u>East St Louis</u> <u>62202</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																	
<b>County:</b> <u>St. Clair</u>																			
<b>Telephone Number:</b> <u>(618) 874-3597</u> <b>Fax #</b> <u>(618) 874-1812</u>																			
<b>IDPA ID Number:</b> <u>369523260001</u>																			
<b>Date of Initial License for Current Owners:</b> <u>06/01/94</u>																			
<b>Type of Ownership:</b>																			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT		<input checked="" type="checkbox"/> PROPRIETARY																	
<input type="checkbox"/> Charitable Corp.		<input type="checkbox"/> Individual																	
<input type="checkbox"/> Trust		<input type="checkbox"/> State																	
<b>IRS Exemption Code</b> _____		<input type="checkbox"/> Partnership																	
		<input type="checkbox"/> Corporation																	
		<input checked="" type="checkbox"/> "Sub-S" Corp.																	
		<input type="checkbox"/> Limited Liability Co.																	
		<input type="checkbox"/> Trust																	
		<input type="checkbox"/> Other _____																	
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>Steve Lavenda</u> <b>Telephone Number:</b> <u>(847) 236 - 1111</u>		<table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Type or Print Name) _____</td> </tr> <tr> <td>(Title) _____</td> </tr> <tr> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) <u>Noshir R. Daruwalla, C.P.A.</u></td> </tr> <tr> <td></td> <td>(Firm Name &amp; Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 236-1111</u> <b>Fax #</b> <u>(847) 236-1155</u></td> </tr> <tr> <td colspan="2"> <b>MAIL TO: OFFICE OF HEALTH FINANCE</b>  <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> <b>Phone # (217) 782-1630</b> </td> </tr> </table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) _____	(Title) _____	(Signed) _____	(Date) _____		(Print Name and Title) <u>Noshir R. Daruwalla, C.P.A.</u>		(Firm Name & Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>		(Telephone) <u>(847) 236-1111</u> <b>Fax #</b> <u>(847) 236-1155</u>	<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b> <b>Phone # (217) 782-1630</b>	
Officer or Administrator of Provider	(Signed) _____																		
	(Date) _____																		
Paid Preparer	(Type or Print Name) _____																		
	(Title) _____																		
	(Signed) _____																		
	(Date) _____																		
	(Print Name and Title) <u>Noshir R. Daruwalla, C.P.A.</u>																		
	(Firm Name & Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>																		
	(Telephone) <u>(847) 236-1111</u> <b>Fax #</b> <u>(847) 236-1155</u>																		
<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b> <b>Phone # (217) 782-1630</b>																			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing Ctr# 0039651 Report Period Beginning: 01/01/03 Ending: 12/31/03

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>150</u>	Skilled (SNF)	<u>150</u>	<u>54,750</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>150</u>	TOTALS	<u>150</u>	<u>54,750</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>7,475</u>	<u>387</u>	<u>2,520</u>	<u>10,382</u>	8
9	SNF/PED					9
10	ICF	<u>28,831</u>	<u>332</u>		<u>29,163</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>36,306</u>	<u>719</u>	<u>2,520</u>	<u>39,545</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 72.23%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)N/A

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 6/1/94

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 6/1/94 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number  
of beds certified 27 and days of care provided 2,520Medicare Intermediary Mutual of Omaha

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/03 Fiscal Year: 12/31/03

\* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number

Virgil Calvert Nursing Ctr

# 0039651

Report Period Beginning:

01/01/03

Ending:

12/31/03

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	183,307	28,187	5,775	217,269		217,269	(1,444)	215,825		1
2	Food Purchase		151,098		151,098		151,098	(27)	151,071		2
3	Housekeeping	114,019	50,208		164,227		164,227		164,227		3
4	Laundry	84,705	19,297		104,002		104,002		104,002		4
5	Heat and Other Utilities			113,479	113,479		113,479	1,413	114,892		5
6	Maintenance	49,032	22,568	14,216	85,816		85,816	1,087	86,903		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	431,063	271,358	133,470	835,891		835,891	1,028	836,919		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			7,000	7,000		7,000		7,000		9
10	Nursing and Medical Records	1,175,873	31,513	3,640	1,211,026		1,211,026	(995)	1,210,031		10
10a	Therapy	74,919		8,295	83,214		83,214		83,214		10a
11	Activities	40,188	615		40,803		40,803		40,803		11
12	Social Services	41,655			41,655		41,655		41,655		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,332,635	32,128	18,935	1,383,698		1,383,698	(995)	1,382,703		16
	<b>C. General Administration</b>										
17	Administrative	58,962		120,000	178,962		178,962	58,834	237,796		17
18	Directors Fees										18
19	Professional Services			144,829	144,829		144,829	(102,578)	42,251		19
20	Dues, Fees, Subscriptions & Promotions			9,180	9,180		9,180	(220)	8,960		20
21	Clerical & General Office Expenses	137,614	2,634	66,358	206,606		206,606	19,376	225,982		21
22	Employee Benefits & Payroll Taxes			264,662	264,662		264,662		264,662		22
23	Inservice Training & Education										23
24	Travel and Seminar			410	410		410	8	418		24
25	Other Admin. Staff Transportation			5,889	5,889		5,889	(2,155)	3,734		25
26	Insurance-Prop.Liab.Malpractice			15,329	15,329		15,329	734	16,063		26
27	Other (specify):*							18,422	18,422		27
28	<b>TOTAL General Administration</b>	196,576	2,634	626,657	825,867		825,867	(7,579)	818,288		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,960,274	306,120	779,062	3,045,456		3,045,456	(7,546)	3,037,910		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Virgil Calvert Nursing Ctr

#0039651

Report Period Beginning:

01/01/03

Ending:

12/31/03

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			56,947	56,947		56,947	225,715	282,662			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			70,180	70,180		70,180	330,437	400,617			32
33	Real Estate Taxes							181,834	181,834			33
34	Rent-Facility & Grounds			720,000	720,000		720,000	(720,000)				34
35	Rent-Equipment & Vehicles			7,737	7,737		7,737	562	8,299			35
36	Other (specify):*							30,088	30,088			36
37	<b>TOTAL Ownership</b>			854,864	854,864		854,864	48,636	903,500			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		58,481	253,623	312,104		312,104		312,104			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,125	82,125		82,125		82,125			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		58,481	335,748	394,229		394,229		394,229			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,960,274	364,601	1,969,674	4,294,549		4,294,549	41,090	4,335,639			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Virgil Calvert Nursing Ctr

# 0039651

Report Period Beginning: 01/01/03

Ending: 12/31/03

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(18,924)	30		9
10	Interest and Other Investment Income	(5,829)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(27)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(16,568)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(135)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(3,899)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (45,382)</b>		<b>\$</b>	<b>30</b>

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	86,473		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ 86,473</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ 41,090</b>		<b>37</b>

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	COPY	28	1
2	Robin Snyder - Admin Salary	16,835	17
3	Robin Snyder - Payroll Tax	1,388	27
4	Betty Gaston - Admin Salary	17,598	17
5	Betty Gaston - Payroll Tax	1,347	27
6	Jeff Davis - Admin Salary	19,630	17
7	Jeff Davis - Payroll Tax	1,581	27
8	Non-Allowable Travel Roomer Kline	(2,615)	25
9	Nonallowable Office Expense	(16,600)	21
10	Nonallowable Legal	-00	19
11	Amortize Mortgage Costs (Bldg. Co.)	(4,670)	31
12	Franchise Fee (Bldg. Co.)	(200)	20
13	Bank Charges (Bldg. Co.)	(25)	71
14	Intracompany Interest	(81,239)	32
15	Finance Charge Income	(1,982)	32
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49			49
50			50
51			51
52			52
53			53
54			54
55			55
56			56
57			57
58			58
59			59
60			60
61			61
62			62
63			63
64			64
65			65
66			66
67			67
68			68
69			69
70			70
71			71
72			72
73			73
74			74
75			75
76			76
77			77
78			78
79			79
80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90			90
91			91
92			92
93			93
94			94
95			95
96			96
97			97
98			98
99			99
100			100
101	Total	(3,899)	101

## Summary A

12/31/03

---

[illegible]

## Summary B

Facility Name & ID Number	Virgil Calvert Nursing Ctr	#	0039651	Report Period Beginning:	01/01/03	Ending:	12/31/03
---------------------------	----------------------------	---	---------	--------------------------	----------	---------	----------

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
30	Depreciation	(18,924)	243,053	1,586									(to Sch V, col.7)
31	Amortization of Pre-Op. & Org.	(4,670)	4,670										225,715
32	Interest	(50,050)	379,240	1,247									30
33	Real Estate Taxes		178,248	3,586									31
34	Rent-Facility & Grounds		(720,000)										32
35	Rent-Equipment & Vehicles			562									33
36	Other (specify):*		30,088										34
37	TOTAL Ownership	(73,644)	115,299	6,981									35
	Ancillary Expense												36
	E. Special Cost Centers												37
38	Medically Necessary Transportation												38
39	Ancillary Service Centers												39
40	Barber and Beauty Shops												40
41	Coffee and Gift Shops												41
42	Provider Participation Fee												42
43	Other (specify):*												43
44	TOTAL Special Cost Centers												44
45	GRAND TOTAL COST												45
	(sum of lines 29, 37 & 44)	(45,382)	123,030	(34,118)	(2,439)								41,090

Facility Name & ID Number Virgil Calvert Nursing Ctr# 0039651

Report Period Beginning:

01/01/03

Ending:

12/31/03

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 720,000	Virgil Calvert Property LLC		\$	\$ (720,000)	1
2	V	32 Interest Income	2,879	Virgil Calvert Property LLC			(2,879)	2
3	V	36 MIP Insurance		Virgil Calvert Property LLC		30,088	30,088	3
4	V	32 Mortgage Interest		Virgil Calvert Property LLC		382,119	382,119	4
5	V	21 Bank Charges		Virgil Calvert Property LLC		25	25	5
6	V	20 Franchise Fee		Virgil Calvert Property LLC		200	200	6
7	V	19 Accounting Fee		Virgil Calvert Property LLC		7,506	7,506	7
8	V	33 Real Estate Taxes		Virgil Calvert Property LLC		178,248	178,248	8
9	V	30 Depreciation		Virgil Calvert Property LLC		243,053	243,053	9
10	V	31 Amortization		Virgil Calvert Property LLC		4,670	4,670	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 722,879			\$ 845,909	\$ * 123,030	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Virgil Calvert Nursing Ctr

# 0039651

Report Period Beginning: 01/01/03

Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 UTILITIES	\$	S.W. MANAGEMENT	100.00%	\$ 1,413	\$ 1,413
16	V	6 REPAIRS AND MAINT.				1,087	1,087
17	V	17 CHIEF FINANCIAL OFFICER				15,902	15,902
18	V	19 PROFESSIONAL FEES				504	504
19	V	20 FEES, SUBSCRIPTIONS, DUES				60	60
20	V	21 CLERICAL AND GENERAL				46,079	46,079
21	V	24 EDUCATION AND SEMINARS				8	8
22	V	25 TRANSPORTATION				460	460
23	V	26 INSURANCE - PROPERTY				734	734
24	V	27 PAYROLL TAXES				11,632	11,632
25	V	30 DEPRECIATION				1,586	1,586
26	V	32 INTEREST EXPENSE				1,247	1,247
27	V	33 REAL ESTATE TAXES				3,586	3,586
28	V	35 AUTO LEASE				562	562
29	V						
30	V	17 SALARY - SHELDON WOLFE				42,869	42,869
31	V	17 SALARY - RONNIE KLEIN				6,000	6,000
32	V	27 EMP. BEN.-SHELDON WOLFE				1,806	1,806
33	V	27 EMP. BEN.-RONNIE KLEIN				847	847
34	V						
35	V	17 MANAGEMENT FEES	60,000				(60,000)
36	V	19 HOME OFFICE FEES	110,500				(110,500)
37	V						
38	V						
39	Total		\$ 170,500			\$ 136,382	\$ * (34,118)

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing Ctr# 0039651Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 DIETARY SUPPLEMENTS	\$ 14,443	S & E MEDICAL SUPPLY	100.00%	\$ 12,999	\$ (1,444)	15
16	V	3 HOUSEKEEPING	911	S & E MEDICAL SUPPLY	100.00%	911		16
17	V	10 MEDICAL SUPPLIES	4,974	S & E MEDICAL SUPPLY	100.00%	3,979	(995)	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 20,328			\$ 17,889	\$ * (2,439)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing Ctr# 0039651Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing Ctr# 0039651Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing Ctr# 0039651Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing Ctr# 0039651Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing Ctr# 0039651Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing Ctr# 0039651Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing Ctr# 0039651Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing Ctr # 0039651 Report Period Beginning: 01/01/03 Ending: 12/31/03

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sheldon Wolfe	President	Administrative	23.67%	See Attached	4.00	6.70%	Sal - SW Mgt	\$ 42,869	17-7	1
2	Ronnie Klein	Shareholder	Administrative	5.50%	See Attached	4.00	10.00%	SW, Fac-Fee	66,000	17-7, 17-3	2
3	Mo Herman	CFO	Administrative	0.67%	See Attached	4.20	10.50%	Sal - SW Mgt	15,902	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 124,771		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing Ctr# 0039651

Report Period Beginning:

01/01/03Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing Ctr# 0039651

Report Period Beginning:

01/01/03Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization S.W. MANAGEMENT  
 Street Address 7434 N. SKOKIE BLVD.  
 City / State / Zip Code SKOKIE, IL. 60077  
 Phone Number ( 847) 982-2300  
 Fax Number ( 847) 982-2304

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5 UTILITIES	AVAIAABLE BED DAYS	525,600	8	\$ 13,562	\$	54,750	\$ 1,413	1
2	6 REPAIRS AND MAINT.	AVAIAABLE BED DAYS	525,600	8	10,440		54,750	1,087	2
3	17 CHIEF FINANCIAL OFFICER	AVAIAABLE BED DAYS	525,600	8	152,661	152,661	54,750	15,902	3
4	19 PROFESSIONAL FEES	AVAIAABLE BED DAYS	525,600	8	4,839		54,750	504	4
5	20 FEES, SUBSCRIPTIONS, DUES	AVAIAABLE BED DAYS	525,600	8	579		54,750	60	5
6	21 CLERICAL AND GENERAL	AVAIAABLE BED DAYS	525,600	8	442,356	384,906	54,750	46,079	6
7	24 EDUCATION AND SEMINARS	AVAIAABLE BED DAYS	525,600	8	75		54,750	8	7
8	25 TRANSPORTATION	AVAIAABLE BED DAYS	525,600	8	4,412		54,750	460	8
9	26 INSURANCE - PROPERTY	AVAIAABLE BED DAYS	525,600	8	7,051		54,750	734	9
10	27 PAYROLL TAXES	AVAIAABLE BED DAYS	525,600	8	111,671		54,750	11,632	10
11	30 DEPRECIATION	AVAIAABLE BED DAYS	525,600	8	15,225		54,750	1,586	11
12	32 INTEREST EXPENSE	AVAIAABLE BED DAYS	525,600	8	11,976		54,750	1,247	12
13	33 REAL ESTATE TAXES	AVAIAABLE BED DAYS	525,600	8	34,428		54,750	3,586	13
14	35 AUTO LEASE	AVAIAABLE BED DAYS	525,600	8	5,396		54,750	562	14
15									15
16	17 SALARY - SHELDON WOLFE	AVG. HOURS WORKED	60	9	643,036	643,036	4	42,869	16
17	17 SALARY - RONNIE KLEIN	AVG. HOURS WORKED	40	7	60,000	60,000	4	6,000	17
18	27 EMP. BEN.-SHELDON WOLFE	AVG. HOURS WORKED	60	9	27,083		4	1,806	18
19	27 EMP. BEN.-RONNIE KLEIN	AVG. HOURS WORKED	40	7	8,473		4	847	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,553,263	\$ 1,240,603		\$ 136,382	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing Ctr# 0039651

Report Period Beginning:

01/01/03Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization S & E MEDICAL SUPPLY  
 Street Address 3100 COMMERCIAL AVENUE  
 City / State / Zip Code NORTHBROOK, ILLINOIS 60062  
 Phone Number ( 847) 982-9300  
 Fax Number ( )

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	<u>DIETARY SUPPLEMENTS</u>	<u>DIRECT ALLOCATION</u>						12,999	1
2	<u>HOUSEKEEPING</u>	<u>DIRECT ALLOCATION</u>						911	2
3	<u>MEDICAL SUPPLIES</u>	<u>DIRECT ALLOCATION</u>						3,979	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 17,889	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing Ctr# 0039651

Report Period Beginning:

01/01/03Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing Ctr# 0039651

Report Period Beginning:

01/01/03Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing Ctr# 0039651

Report Period Beginning:

01/01/03Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing Ctr# 0039651

Report Period Beginning:

01/01/03Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing Ctr# 0039651

Report Period Beginning:

01/01/03Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing Ctr# 0039651

Report Period Beginning:

01/01/03Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing Ctr # 0039651 Report Period Beginning: 01/01/03 Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related													
	Long-Term													
1							\$					\$	1	
2	Mortgage		X						5,993,552				382,119	2
3														3
4														4
5	See Supplemental Schedule													5
	Working Capital													
6	N/P-Stockholders(Bank One)		X						735,586				27,941	6
7	Intercompany Loan	X											42,239	7
8	See Supplemental Schedule													8
9	TOTAL Facility Related						\$		\$ 6,729,138			\$ 452,299		9
	B. Non-Facility Related*													
10														10
11	Interest Income		X										(5,829)	11
12	Alloc SW Mgmt		X										1,247	12
13	See Supplemental Schedule												(47,100)	13
14	TOTAL Non-Facility Related						\$		\$			\$ (51,682)		14
15	TOTALS (line 9+line14)						\$		\$ 6,729,138			\$ 400,617		15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ None      Line # N/A

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)      SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
6												6	
7	TOTAL Long-Term											7	
	Working Capital												
8							\$	\$			\$	8	
9												9	
10												10	
11												11	
12												12	
13												13	
14	TOTAL Working Capital											14	
	B. Non-Facility Related*												
15	Interest Income (Bldg Co.)		X				\$	\$			\$ (2,879)	15	
16	Intercompany Ln(Nonallow)	X									(42,239)	16	
17	Finance Charge Income		X								(1,982)	17	
18												18	
19												19	
20	TOTAL Non-Facility Related										(47,100)	20	

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name & ID Number **Virgil Calvert Nursing Ctr**# **0039651** Report Period Beginning: **01/01/03** Ending: **12/31/03****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2002 report.			\$	<b>136,831</b>	1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	<b>157,283</b>	2	
3. Under or (over) accrual (line 2 minus line 1).			\$	<b>20,452</b>	3	
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<b>161,382</b>	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$      For      Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<b>181,834</b>	7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	1998	<b>83,907</b>	8			
	1999	<b>91,676</b>	9			
	2000	<b>112,153</b>	10			
	2001	<b>130,316</b>	11			
	2002	<b>153,697</b>	12			
<b>2003 Accrual - \$153,697 X 1.05 = \$161,382</b>				13	FROM R. E. TAX STATEMENT FOR 2002 \$	13
<b>Allocate SW Management - \$3,586</b>				14	PLUS APPEAL COST FROM LINE 5 \$	14
				15	LESS REFUND FROM LINE 6 \$	15
				16	AMOUNT TO USE FOR RATE CALCULATION \$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2002 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Virgil Calvert Nursing Ctr COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0039651

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>02-21-0-209-021</u>	<u>Long Term Care Property</u>	\$ <u>153,697.14</u>	\$ <u>153,697.14</u>
2. <u>10-28-412-049-0000</u>	<u>Alloc. SW Management</u>	\$ <u>35,796.06</u>	\$ <u>3,586.24</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>189,493.20</u>	\$ <u>157,283.38</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?  X  YES   NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2002 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Virgil Calvert Nursing Ctr COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0039651

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
2.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
3.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
4.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
5.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
6.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
7.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
8.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
9.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
10.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
		<b>TOTALS</b>	\$ <u>                    </u>	\$ <u>                    </u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?            YES            NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A. Square Feet: \_\_\_\_\_

B. General Construction Type:
 

Exterior \_\_\_\_\_

Frame \_\_\_\_\_

Number of Stories \_\_\_\_\_

C. Does the Operating Entity?
 

☐

 (a) Own the Facility
 

☒

 (b) Rent from a Related Organization.
 

☐

 (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 

☒

 (a) Own the Equipment
 

☒

 (b) Rent equipment from a Related Organization.
 

☒

 (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 

☐

 YES
 

☒

 NO

If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_

2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_

3. Current Period Amortization: \_\_\_\_\_

4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_  
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		2001	\$ 400,000	1
2					2
3	TOTALS			\$ 400,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment.** (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Various			1994	30,236		20	1,512	1,512	13,897	9
10	Various			1995	25,180		20	1,260	1,260	11,159	10
11	Various			1996	5,688		20	284	284	2,178	11
12	Various			1997	4,115		20	206	(206)	1,373	12
13	Various			1998	4,092		20	205	205	1,398	13
14	Various			1999	27,640		20	1,430	1,430	6,219	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

**\*\*Improvement type must be detailed in order for the cost report to be considered complete.**

## STATE OF ILLINOIS

Page 12B

Facility Name &amp; ID Number Virgil Calvert Nursing Ctr

# 0039651

Report Period Beginning:

01/01/03

Ending:

12/31/03

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,953,341	\$ 190,353		\$ 138,788	\$ (51,565)	\$ 326,428	1
2	Concrete Work	2000	3,181		20	159	159	557	2
3	Concrete Work	2000	5,030		20	252	252	881	3
4	Concrete Work	2000	5,195		20	260	260	910	4
5	Exhaust Fan	2000	3,820		20	191	191	923	5
6	Water Heater	2000	5,300		20	265	265	1,237	6
7	Carpeting	2000	5,400		20	270	270	1,170	7
8	Mechanical Room Volv	2000	1,315		20	66	66	198	8
9	Check Valve	2000	877		20	44	44	132	9
10	Plumbing	2000	1,024		20	51	51	153	10
11	100 Gal. Waterheater	2001	4,642		20	397	397	1,767	11
12	Steamer	2001	2,545		20	218	218	968	12
13	Concentrator	2001	2,703		20	231	231	1,029	13
14	Air Conditioner	2001	1,895		20	162	162	721	14
15	Fire Protection	2001	6,752		20	577	577	2,570	15
16	Air Conditioner	2001	8,313		20	711	711	3,164	16
17	Sprinkler Heads	2001	3,273		20	280	280	1,246	17
18	Blinds	2001	1,212		20	104	104	462	18
19	Sprinkler System Rep	2001	1,827		20	91	91	213	19
20	Heating Systems Repr	2001	1,269		20	63	63	132	20
21	Dining Room Wall	2002	11,663		20	1,166	1,166	1,944	21
22	Dining Room Wall	2002	8,020		20	802	802	1,337	22
23	Air Conditioners	2002	1,659		20	237	237	375	23
24	Air Conditioners	2002	2,185		20	312	312	494	24
25	Front Door	2003	9,860		20	493	493	493	25
26	Roof	2003	72,800		20	3,033	3,033	3,033	26
27	Gutters And Soffits	2003	24,221		20	807	807	807	27
28	Nursing Station	2003	2,901		20	109	109	109	28
29	Nursing Station	2003	13,285		20	498	498	498	29
30	Nursing Station	2003	12,188		20	254	254	254	30
31	Fire Sprinkler System	2003	2,075		20	61	61	61	31
32	Fire Suppression System	2003	2,030		20	51	51	51	32
33	100 Gl. Water Heater	2003	3,085		20	154	154	154	33
34	TOTAL (lines 1 thru 33)		\$ 5,184,886	\$ 190,353		\$ 151,157	\$ (39,196)	\$ 354,471	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**\*\*Improvement type must be detailed in order for the cost report to be considered complete.**

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 5,192,145	\$ 190,353		\$ 151,399	\$ (38,954)	\$ 354,713	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,192,145	\$ 190,353		\$ 151,399	\$ (38,954)	\$ 354,713	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**\*\*Improvement type must be detailed in order for the cost report to be considered complete.**

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 5,192,145	\$ 190,353		\$ 151,399	\$ (38,954)	\$ 354,713	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,192,145	\$ 190,353		\$ 151,399	\$ (38,954)	\$ 354,713	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 5,192,145	\$ 190,353		\$ 151,399	\$ (38,954)	\$ 354,713	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,192,145	\$ 190,353		\$ 151,399	\$ (38,954)	\$ 354,713	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**\*\*Improvement type must be detailed in order for the cost report to be considered complete.**

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**	Year	Cost	Current Book	Life	Straight Line	Adjustments	Accumulated	
Constructed			Depreciation	in Years	Depreciation		Depreciation	
1	Totals from Page 12H, Carried Forward	\$ 5,192,145	\$ 190,353		\$ 151,399	\$ (38,954)	\$ 354,713	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 5,192,145	\$ 190,353		\$ 151,399	\$ (38,954)	\$ 354,713	34

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 5,192,145	\$ 190,353		\$ 151,399	\$ (38,954)	\$ 354,713	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,192,145	\$ 190,353		\$ 151,399	\$ (38,954)	\$ 354,713	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 5,192,145	\$ 190,353		\$ 151,399	\$ (38,954)	\$ 354,713	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,192,145	\$ 190,353		\$ 151,399	\$ (38,954)	\$ 354,713	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment.** (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	150		2001		\$ 4,801,297	\$ 132,029		\$ 132,029	\$	\$ 275,061	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-BLDG, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,801,297	\$ 132,029		\$ 132,029	\$	\$ 275,061	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.
 SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)												
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.												
	1		2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6				1995	45,087	1,156	35	1,288	132	11,149	6	
7											7	
8											8	
	Improvement Type**											
9	SW Management Allocation			1995	4,810	73	20	287	214	2,421	9	
10	SW Management Allocation			1996	840	21	20	42	21	318	10	
11	SW Management Allocation			1997	1,210	47	20	87	40	543	11	
12	SW Management Allocation			1998	833	21	20	42	(21)	240	12	
13	SW Management Allocation			1999	2,313	59	20	116	57	472	13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36											36	

\*Total beds on this schedule must agree with page 2.
 See Page 12A-REP, Line 70 for total

\*\*Improvement type must be detailed in order for the cost report to be considered complete.
 SEE ACCOUNTANTS' COMPILATION REPORT

## XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 55,093	\$ 1,377		\$ 1,862	\$ 443	\$ 15,143	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 946,532	\$ 111,085	\$ 130,389	\$ 19,304	10	\$ 343,289	71
72	Current Year Purchases	14,746	147	873	726	10	873	72
73	Fully Depreciated Assets	1,320				10	1,320	73
74								74
75	TOTALS	\$ 962,598	\$ 111,232	\$ 131,262	\$ 20,030		\$ 345,482	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,554,743	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 301,585	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 282,661	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (18,924)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 700,195	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

## XII. RENTAL COSTS

### A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy: ☐ YES ☐ NO Terms: \_\_\_\_\_ \*

### B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 924

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

### C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Business	2002 Chrysler Sebring	\$ 563.06	\$ 6,813	17
18	Allocate SW Mgmt			562	18
19					19
20					20
21	TOTAL		\$ 563.06	\$ 7,375	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2004 \$ \_\_\_\_\_

13. /2005 \$ \_\_\_\_\_

14. /2006 \$ \_\_\_\_\_

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility		2	3	4
		Drop-outs	Completed	Contract	Total	
1	Community College Tuition	\$	\$	\$	\$	
2	Books and Supplies					
3	Classroom Wages (a)					
4	Clinical Wages (b)					
5	In-House Trainer Wages (c)					
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS	\$	\$	\$	\$	
10	SUM OF line 9, col. 1 and 2 (e)	\$				

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
(c) For in-house training programs only. Do not include fringe benefits.  
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.  
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 125,446	\$		\$ 125,446	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			30,016			30,016	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			98,161			98,161	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				45,452		45,452	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						13,029		13,029	13
14	TOTAL			\$		\$ 253,623	\$ 58,481		\$ 312,104	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 126,306	\$ 222,450	1
2	Cash-Patient Deposits	21,974	21,974	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	796,838	796,838	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	18,266	48,085	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	266,313	133,285	8
9	Other(specify): See Attached Schedule	(3,049)	265,322	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,226,648	\$ 1,487,954	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		400,000	13
14	Buildings, at Historical Cost		4,513,385	14
15	Leasehold Improvements, at Historical Cost	187,157	475,070	15
16	Equipment, at Historical Cost	307,973	1,085,142	16
17	Accumulated Depreciation (book methods)	(279,762)	(786,123)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule		153,713	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 215,368	\$ 5,841,187	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 1,442,016	\$ 7,329,141	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 173,506	\$ 173,506	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	27,728	27,728	28
29	Short-Term Notes Payable	735,586	735,586	29
30	Accrued Salaries Payable	72,308	72,308	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,307	3,307	31
32	Accrued Real Estate Taxes(Sch.IX-B)		161,382	32
33	Accrued Interest Payable		31,716	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	See Attached Schedule	733,313	733,313	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,745,748	\$ 1,938,846	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,993,552	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	See Attached Schedule			43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$ 5,993,552	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,745,748	\$ 7,932,398	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (303,732)	\$ (603,257)	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 1,442,016	\$ 7,329,141	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(124,986)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Rounding Adjustment</b>	<b>7</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(124,979)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(178,753)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(178,753)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(303,732)</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,866,674	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,866,674	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	226,517	6
7	Oxygen	13,794	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 240,311	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	7,811	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 7,811	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See Supplemental Schedule	1,000	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,000	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,115,796	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	835,891	31
32	Health Care	1,383,698	32
33	General Administration	825,867	33
<b>B. Capital Expense</b>			
34	Ownership	854,864	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	312,104	35
36	Provider Participation Fee	82,125	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,294,549	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(178,753)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (178,753)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Virgil Calvert Nursing Ctr# 0039651Report Period Beginning: 01/01/03Ending: 12/31/03

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,000	2,080	\$ 64,419	\$ 30.97	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,592	8,974	203,551	22.68	3
4	Licensed Practical Nurses	15,472	16,347	309,135	18.91	4
5	Nurse Aides & Orderlies	65,210	69,534	598,768	8.61	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,328	6,029	74,919	12.43	8
9	Activity Director					9
10	Activity Assistants	5,035	5,343	40,188	7.52	10
11	Social Service Workers	3,153	3,550	41,655	11.73	11
12	Dietician					12
13	Food Service Supervisor	1,806	2,073	27,897	13.46	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,942	19,187	155,410	8.10	15
16	Dishwashers					16
17	Maintenance Workers	3,815	4,087	49,032	12.00	17
18	Housekeepers	14,254	15,250	114,019	7.48	18
19	Laundry	9,828	10,728	84,705	7.90	19
20	Administrator	1,928	2,080	58,962	28.35	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,374	10,429	137,614	13.20	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	163,737	175,691	\$ 1,960,274 *	\$ 11.16	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	77	\$ 5,775	01-03	35
36	Medical Director	65	7,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	47	3,640	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	86	8,295	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	275	\$ 24,710		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

## **XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	%	Amount	Description		Amount	Description		Amount		
Kathleen Crawford	Administrator	0	\$ 58,962	Workers' Compensation Insurance		\$ 51,433	IDPH License Fee		\$		
				Unemployment Compensation Insurance		32,021	Advertising: Employee Recruitment				
				FICA Taxes		149,961	Health Care Worker Background Check (Indicate # of checks performed _____)		2,590		
				Employee Health Insurance			IL Council Dues		5,120		
				Employee Meals			Subscriptions		25		
				Illinois Municipal Retirement Fund (IMRF)*			Inspections		195		
				Health & Welfare		31,027	Licenses and Permits		970		
				Disability		220	Allocate SW Mgmt		60		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)							Less: Public Relations Expense (				
B. Administrative - Other							Non-allowable advertising (				
							Yellow page advertising (				
Description			Amount				TOTAL (agree to Sch. V, line 20, col. 8)				
SW Management Fee			\$ 60,000				\$ 8,960				
Ronnie Klein Administrative			60,000								
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)						\$ 120,000					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description		Amount		
Personnel Planners	Unemployment Consultant		\$ 1,347			\$	Out-of-State Travel		\$		
FR&R	Accounting		16,200								
Richard Keyes	Legal		88								
Winston & Strawn	Legal		5,440				In-State Travel				
Ashman & Stein	Legal		353								
Burroughs, Helper, Broom	Legal		9,581								
SW Management	Home Office		110,500				Seminar Expense		410		
LTC Solutions	Computer Service		1,320				Allocate SW Mgmt		8		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)				TOTAL				Entertainment Expense (			
			\$ 144,829			\$	(agree to Sch. V, line 24, col. 8)				
							TOTAL		\$ 418		

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

**\*\*See instructions.**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Virgil Calvert Nursing Ctr

STATE OF ILLINOIS

# 0039651

Report Period Beginning:

01/01/03

Ending:

Page 23

12/31/03

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IL Council \$5,400
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ None Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? Yes  
If YES, give effective date of lease. 6/1/94
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 82,125  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ \_\_\_\_\_ Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
g. Does the facility transport residents to and from day training? N/A  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.